OR PREP AND HOLD

STANDARD OPERATING PROCEDURE

500 BED FLEET HOSPITAL

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OR PREP AND HOLD

A. **MISSION:** Continue emergency care and treatment and/ or sustain care established prior to the casualty/ patient arriving in the Prep and Hold area. Prepare casualties/ patients for entry into the Operating Room (OR) and provide post anesthesia recovery for the Inpatient Wards.

B. **FUNCTIONS:**

Perform secondary triage/ treatment area staging patients for the Operating Room.

Capabilities not included: Definitive surgical care, reconstruction and elective surgical procedures. Prep and hold is not designed to maintain those patients who are unable to support life functions without medical intervention. It is designed to sustain life and limb for a limited time, provide a control point of Operating Room utilization and to prepare patients pre-operatively.

C. **PHYSICAL DESCRIPTION OF FUNCTIONAL AREA:**

1. Space is limited.

2. Supports a combination of field hospital beds and litter supports.

D. **SPECIAL CONSIDERATIONS/HAZARDS:**

1. The staff does not need to be Operating Room personnel but should be skilled in trauma or critical care.

2. All patients requiring surgery should be routed through Prep and Hold before going into the Operating Room.

3. If possible and necessary, an authorization for surgery and Anesthesia (SF-522) will be obtained.

4. In a contingency, the OR continues surgery until all patients requiring surgical care have been served. There is NO published OR schedule. The surgical tracking team monitors all patients awaiting surgery or OR availability. As OR tables become available, Prep and Hold is notified and the patient is sent to the OR.

5. Length of stay in this area is contingent upon the patient's condition, surgical priority as well as Operating Room availability. The surgical triage process is dynamic and fluid necessitating frequent update. Therefore;

6. Once an Operating Room backlog begins, patients awaiting surgery must be held either on the Intensive Care Unit (ICU) or the Inpatient ward to which they are admitted. This will prevent Prep and Hold from becoming another intra-hospital movement point as surgical priority changes. OR personnel will notify the ICU/ward when to send patient to Prep and Hold.

7. Humidity and temperature control within each module will be difficult to maintain in the optimal ranges. Therefore, these should not be a major focus of the staff.

8. Scrub suites are appropriate wear for personnel on duty in this area.

9. Personnel from OR may be tasked to assist to remove unexploded ordinances from a casualty. An explosive ordinance team should include one surgeon, one OR tech and one anesthesia staff member. All personnel assigned duty, as Explosive Ordinance Team must be thoroughly trained, this training should occur pre-deployment). The team will perform ordinance removal in an area away from the OR and must wear protective clothing (flack jacket/helmet). Once the ordinance has been removed and transferred to the proper Ordinance Disposal Team, the patient will be transported to the OR module for completion of the procedure(s).

10. Standard procedures/ routines are located in the Director of Nursing Service SOP. Lippincotts Manual for Nursing Practice, current Edition is the reference for nursing procedures in the Fleet Hospital.

11. All personnel assigned duty in the OR Prep and Hold must be thoroughly familiar with equipment used in the course of a duty day. This training should occur pre-deployment, as the demands placed on the OR in theater may not enable the department to train personnel "as they go". Training in theater may be limited to orientation only. It is recommended that the department obtain descriptions of Prep and Hold equipment and supplies during pre-deployment to provide familiarization.

12. Tracking of OR backlog time is critical. Estimated times projected for specific casualty conditions or multiple wound situations are found in the DEPMEDS Clinical Guidelines and Treatment Briefs. These guidelines may be obtained from the Universal Data Repository (UDR), which Command Management Information Department (MID) should have. Actual times may vary,

but projecting backlog using the DEPMED information provides a guide of anticipated workload and OR time.

13. If accidentally punctured or cut with contaminated sharp:

(a) Notify Circulating Nurse or OR Supervisor.

(b) Seek first aid.

(c) Complete incident report on NAVMED 6010/14.

E. DEPARTMENT ORGANIZATIONAL STRUCTURE:

1. Responsibility.

(a) A General Surgeon should be identified as the Ward Medical Officer for Prep and Hold. He/ she will provide overall guidance for post anesthesia recovery and pre surgical care.

(b) The Surgeon designated as Head of Surgical Department (Chief of Surgery) provides the overall policy implementation and establishes procedures utilized in the Operating Room.

2. Staffing.

(a) Patient care staff for Prep and Hold is provided by the Director of Nursing Service and should not be OR staff. Consideration should be given to personnel who have a trauma/ critical care background.

3. Watch Bill.

In developing the watch bills for Prep and Hold the following apply:

(a) The OR does not provide staff for Prep and Hold.

(b) Surgery is a 24 hour a day, seven day a week operation that is open and working until all surgical cases have been complete.

(c) Staffing ratios will be based on contingency for which the hospital is employed. The Director of Nursing Service will publish the staffing/ watch bills for this area. However, watches stood will be confined to this work site.

(d) Off duty Prep and Hold personnel always on call.

4. Special Watches.

(a) For the most part, personnel assigned to Prep and Hold should be exempt from any other watches due to the 24 hours availability requirement of this department

F. **JOB DESCRIPTIONS:**

1. Prep and Hold Supervisor - accountable for all nursing care activities, unit operation and staff functions in accordance with Fleet Hospital Policy. Must demonstrate administrative, leadership and teaching abilities with effective interpersonal and intradepartmental relationship.

2. Staff Nurse - responsible for the nursing care of assigned patients during a given period of time. Also, the direction and supervision of personnel assigned to him/her.

3. Job descriptions are maintained by the Directorate having policy control over the Department/ Functional area. Job description for Prep and Hold are located in the Director of Nursing Services SOP

G. **WORKLOAD:** Variable.

H. **TASKS :**

1. Continual assessment on patient vital signs is paramount.

2. Monitor dressings, drains, IV's and tourniquets.

3. Review admission notes and other records accompanying patient.

4. Check for allergies (dog-tag and medical alert tags).

5. Perform pre-operative nursing care.

6. Keep patient NPO.

7. When patient condition permits, prep surgical site(s). When standard prep is not possible, remove as much dirt and debris from the site and adjacent area as possible.

8. Insert IV catheters, IV's, tubes if ordered and not done prior to arrival.

9. Prepare and complete pre-surgical checklist and place in patient record when patient transported for surgery.

I. STANDARD OPERATING PROCEDURE (UNIQUE FIELD ENVIRONMENT):

1. Close communication between the OR and Prep Hold and the Surgical Tracking team is required to promote a steady and appropriate flow of patients.

2. The Surgical tracking team will notify Patient Admin Dept. of OR backlog at the change of each shift, upon request or when there is significant change in the amount of time backlogged.

3. Once OR backlog time begins, very few if any casualties will be sent directly to Prep and Hold. Instead they should be admitted to either ICU or to an Inpatient ward and the OR notified of their location and diagnosis.

4. When an Operating room is available, the OR will notify the area holding the patient to send the patient to Prep and Hold. The area holding the patient will notify Prep and Hold prior to moving the patient.

5. ICU patients requiring anesthesia recovery should be recovered on the ICU. The Prep and Hold staff should recover only patients from the ward as the wards are not staffed or equipped to perform this function.

J. CLINICAL POLICIES AND GUIDELINES:

1. Priorities of surgical treatment:

   (a) First priority – Patients with injuries resulting in asphyxia or hemorrhage.

   (b) Second priority – Surgery performed after resuscitative measures are completed.

   (c) Third priority – Surgery performed after pre-op preparation on wounds, which cause morbidity if left, untreated for prolonged period.

   (d) Fourth priority – Head injuries with loss of consciousness, brain and spinal cord injuries where decompression is required.

2. Daily Turn Over:

(a) Daily checking and turnover of all equipment within Prep and Hold will be accomplished before start of each shift. Prep and Hold operates for the entire 24-hour period, equipment will be checked while operated. Equipment requiring maintenance or repair will be removed from service immediately and sent to Medical Repair. Surgical equipment should be given the highest priority for medical repair attention and returned to service.

3. Equipment Inspection.

(a) Check emergency equipment for proper function each watch or as caseload permits.

(b) Report major equipment malfunction to OR Prep and Hold supervisor.

4. Obtaining Blood Products.

(a) Call the Blood Bank (laboratory) for blood products needed for a procedure. Store in refrigerator located in OR support module.

5. Nursing care of the patient awaiting surgery.

(a) Immediately pre-op, efforts are made to provide a calm, professional atmosphere and to promote confidence on the part of the patient.

6. Cardiac arrest.

(a) In the event of cardiac arrest, the Circulating Nurse will record time of arrest on Operative Record and on Cardiac Arrest Flow Sheet.

(1) If the patient expires, follow the hospital procedure for postmortem care.

(2) Prepare notice of Death (NAVMED 6320/5)

(3) Record in Nursing Notes, the time of death, surgeon making the pronouncement and the name of individual contacted to secure the deceased's personal effects.

7. Release of Information.

(a) OR personnel will not discuss the status of any patient or procedure with personnel outside of the OR area unless specifically directed to do so.

K. RESPONSE TO DEPLOYMENT HAZARDS

1. FIRE PROCEDURES

- **Initially, attempt to extinguish a fire with a portable fire extinguisher ONLY IF THE FIRE IS CONTAINED.**

- Simultaneously, the Functional Area (FA) needs to IMMEDIATELY contact ADMIN either by phone or runner/messenger. ADMIN WILL SOUND THE ALARM FOR FIRE.

- Smoke boundaries need to be set by the FA staff by dropping the TEMPER liner flaps leading to the FA and vestibules(s). All flaps throughout the hospital need to be dropped to control the possible flow of smoke.

- The FA Leader will decide to evacuate the space if the fire is determined to be out of control.

- All O2 cylinders (on a cart) positioned in each appropriate FA need to be removed when the space is evacuated.

- A FA staff member should be assigned in each area to secure the electrical (C-panel) and HVAC units.

- A muster of all staff and patients within the affected FA needs to be taken immediately and sent to ADMIN by runner.

- The FA Leader needs to wait at the FA access point for the Fire Marshall and Fire Team to arrive in order to report: type of fire, volatile items in the space (O2 cylinders, HAZMAT) and any casualties known to be in the space.

- When assessing the intensity of the fire, the Fire Marshall WILL DECIDE WHETHER OR NOT THE ADJACENT FUNCTIONAL AREA (S) WILL EVACUATE. Therefore, the FA on either side of the area of fire will wait for the word from the Fire Marshall before evacuating.

- Once the fire is out, there will be an inspection of the damaged area by the Fire Marshall, FA Leader and other key personnel.

- The Fire Marshall will give an assessment report to the Commanding Officer describing damages sustained by the FA. Depending on the outcome of the fire, the FA may need to relocate somewhere else until it is fully functional again. The FA Leader needs to await orders from the Command Staff before reentering the FA and returning to duty.

2. CHEMICAL/ BIOLOGICAL ATTACK

- The hospital ADMIN department will notify the hospital compound, via 1MC, if there is a possibility of a biological/chemical attack.

- All areas of the compound must respond appropriately

- Once the alarm has been sounded for biological/chemical attack, THE INITIAL ACTION TAKEN IS TO DON AND CLEAR YOUR GAS MASK. Since the fleet hospital is operational, sleeves should always be down. **The donning and clearing of the gas mask should be accomplished in a total of 8 seconds**.

- If a MOPP level is required, the ADMIN department will announce that accordingly and everyone will proceed to MOPP Level 4. **This task must be accomplished within 8 minutes.**

- Once Personal MOPP gear is on, place gas masks on your patients.

- One person from each FA should be assigned to secure the HVAC unit (to prevent gas from entering FA). DO NOT DROP THE FLAPS IN THE HOSPITAL! The designated person should NOT reenter the hospital but should proceed to the EOD/Decontamination bunker.

- A muster of all FA staff and patients needs to be taken immediately and sent to ADMIN.

- **Drink water!! Hydration, hydration, hydration.**

- The ALL CLEAR will be announced by ADMIN over the 1MC.

3. AIR RAID PROCEDURES

- Once the alarm has been sounded for air attack**, THE INITIAL ACTION TAKEN IS TO EVACUATE ALL FA STAFF AND PATIENTS TO THE BUNKERS.** The entire compound must evacuate to appropriate bunkers including living spaces/GPL's and the COMMZ

- Conduct an accurate muster of all staff personnel and patients immediately and submit it to the ADMIN bunker.

- Be sure to bring all gear including canteens since mustering may require everyone to be standing outside for long periods of time.

- It's not necessary to secure C-panel or HVAC during an air raid drill. Evacuate to bunkers ASAP.

- When announced over the 1MC, each FA must send in two junior personnel to search and sweep high, medium and low on both sides of the FA to check for bombs. All other personnel will stay outside in bunkers until area is cleared. The All Clear will be announced over the 1MC.

- MISCELLANEOUS ITEMS

- Each FA should denote a supply petty officer that is responsible for equipment inventory/high-tech gear checkout. If supplies are needed, submit a request to the student SK's/supply department for issue. The student SK's will request supplies from FHOTC supply if NIS.

- If trouble arises with HVAC or C-panel (electrical power), submit a work request to the student Public Works department. Both the HVAC and C-panel operations remain off-limits to students other than Seabees.

- Rear doors to FA are to be used only as evacuation routes or for patient flow during peak flow ONLY. There are only two ways to enter the hospital…either on foot by the ADMIN temper or through CAS REC via litter.

- Each FA needs to have a logbook or similar system in order to keep track of all staff and patients within the compound. Each time a staff member or patient leaves the FA, he/she must be logged out (time, location) and then logged back in when he/she returns. This will assist with accuracy when conducting musters.

L. PATIENT PROCEDURES FOR HANDLING ENEMY PRISONERS OF WAR

PURPOSE: To detail patient handling procedures for enemy prisoners of war within the fleet hospital.

DEFINTION:

Enemy prisoners of war (EPW) – those who require treatment who are prisoners of U.S. or allied combat forces.

EQUIPMENT, SUPPLIES, AND FORMS REQUIRED:

1. Restraints (theater command military police or hospital issue).

2. Others as specified in admission procedures (all forms will be marked with the words “Prisoner of War” or “EPW”).

STEPS:

1. Upon presentation of EPW to functional area, notify the Security Department and Patient Admin.

2. Upon admission to Casualty Receiving, Security will be responsible for the following notifications:

   (a) Theater command military police (MP) headquarters.

   (b) Executive Officer.

   (c) Director of Nursing.

   (d) Director of Administration.

3. Perform essential life saving care.

4. Inform MP that hospital staff will not assume custody of patient, and that MP will retain custody of EPW until relieved by appropriate MP headquarters staff or patient is transferred to EPW holding center (external to hospital).

5. After treatment, have corpsman or litter bearer escort MP and EPW to next functional area charge nurse. A correctly annotated admissions packet will be delivered by hand to the charge nurse.

6. During course of treatment, patient will be guarded by MP and/or restrained until treatment is terminated.

7. Movement to another functional area will be reported to Security.

8. EPW's will be fed either on the ward or in the general mess. If allowed to eat in the general mess, EPW's will be accompanied by MP guards.

RESONSIBILITY:

CMAA/Security.